2018 For Office Use Only: $ Before___________________ **$** After_______________________

Drug List ID: _________________________________ Password Date: ______________________

MEDICARE PRESCRIPTION DRUG COVERAGE WORKSHEET

NAME: ____

ADDRESS: ____

CITY: _______________________________ ZIP: ________________

PHONE: __________________________________ COUNTY: _________ RACE: _____________

EMAIL: ____

MEDICARE ID NUMBER: _______________________ BIRTH DATE: ______________________

EFFECTIVE DATE FOR PART A_____________ FOR PART B___________

Contact information if you are handling this worksheet for someone else:
Name_______________________________________ Phone: __________________________________

Address: ____

Email: ____

1. Do you currently have a Part D Prescription Drug Plan? Yes_____ No_____
If yes, what company? ___________________________ What Plan? ____________________

2. Do you receive Extra Help from Social Security? Yes_____ No_____
Are you eligible for extra help but not currently receiving it (see guidelines below)? Yes______ No_______

2018 annual income and resource limits to qualify for Extra Help
Single – Single - $1538 or less income/$14,100 or less for resources (assets)
Married (living w/spouse) - $2078 or less income/$28,150 or less for resources (assets)

****

–HOW DO I GET HELP DECIDING WHAT PRESCRIPTION DRUG I NEED?

1. **Complete this worksheet and return it to Denise Dias, Johnson County K-State Research & Extension**
2. **You will be mailed/emailed a comparison of the top 3 plans w/an explanation and instructions.**
3. **If you would still like help or require further assistance call 913-715-7013.**

*****Please list all the prescription medications you take on the back*****

Donations can be given to the Johnson Co. Extension Education Foundation
Memo: SHICK
Thank you for your generosity!

*****If you take a generic medication, please write down that name, rather than listing the brand name.**

	Drug List ID: ____________ Password Date: ____________ $ Before: ____________ $ After: ____________				
	Please print the info below				
	Complete Drug Name	**Will you take generic if available?**	**Capsule or Tablet**	**Dosage/ Strength**	**# of Pills Taken Per Day** (Example: 1 tab 2 x daily)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

Comments: ____

Please list your local pharmacy (we cannot run comparisons for mail order pharmacies). Please include name and address.

YOU WILL BE EMAILED OR MAILED PLAN INFORMATION ON THE TOP 3 PLANS FROM THE MEDICARE WEBSITE. CALL UPON RECEIVING IT IF YOU NEED FURTHER ASSISTANCE. 913-715-7013.

RETURN THIS FORM TO:

Denise Dias, Johnson County K-State Research & Extension
11811 S Sunset Drive Suite 1500, Olathe, KS 66061, denise.dias@jocogov.org